DATE

7/6/98

## **United States Bankruptcy Court** PROOF OF CLAIM District of Idaho Complete this form and mail to: U.S. Bankruptcy Court 550 W.Fort St. Boise, ID 83724 U.S. COURTS Name of Debtor: Case Number: COMMUNITY HOME HEALTH INC 98-02141 Chapter: Trustee: Proof of claim form and all supporting documents must be filed in DUPLICATE on Chapter 12 and 13 cases This form should not be used to make a claim for an administrative expense arising after the commencement, of the case. A "request" for payment of an administrative expense may be flied pursuant to U.S.C. §503 Name of Creditor (The person or other entity to whom the debtor owes Check box if you are aware that anyone else has filed a proof of claim money or property): relating to your claim. Attach copy of statement giving particulars. Rebecca M. Thucker ☐ Check box if you have never received any notices from the bankruptcy court in this case. □ Check box if the address differs from the address on the envelope. Account or other number by which identifies debtor: Check here if this claim: Replaces Amends a previously filed claim dated: Services Performed ☐ Money Loaned Personal Injury/Wrongful Death 1. Basis for Claim Goods Sold ☐ Taxes ☐ Other (please describe): ☐ Retiree benefits as defined in 11 U.S.C. §1114(a) Your Social Security Number: Wages, Salaries and compensation: ☐ Unpaid Compensation for services performed from **U**/ 3. If court Judgment, date obtained: 4 2. Date debt was incurred: 5. UNSECURED PRIORITY CLAIM 4. SECURED CLAIM ☐ Check box if your claim is secured by collateral □ Check box if you have an unsecured priority claim (including a right of setoff) Brief Description of Collateral: ☐ Real Estate ☐ Motor Vehicle Other | SPECIFY PRIORITY OF CLAIM Value of Collateral \$ \_ Amount of arrearage and other charges at time the case was filed ☐ Wages, Salaries, or commissions (up to \$4000)\* earned within 90 days before filing included in secured claim, if any: of the bankruptcy petition or cessation or the debtor's business, whichever is earlier. (11 U.S.C. § 507 (a)(3)) ☐ Contributions to an employee benefit plan (11 U.S.C. § 507 (a)(4)) ☐ Up to \$1,800\* of deposits toward purchase, lease, or rental of property or services for 6. TOTAL AMOUNT OF CLAIM AT TIME CASE WAS FILED personal, family or household use (11 U.S.C. § 507 (a)(6)) ☐ Alimony, maintenance, or support owed to a spouse, former spouse or child UNSECURED \$ SECURED \$ (11 U.S.C. § 507 (a)(7)) ☐ Taxes or penalties owed to governmental units (11 U.S.C. § 507 (a)(8)) ☐ Other - Specify applicable paragraph of (11 U.S.C. § 507 (a)( ) ☐ Check box if claim includes interest or other charges in addition to \*Amounts are subject to adjustment on 4/1/98 and every 3 years thereafter with respect to cases commenced on or after the date of adjustment. the principal amount of the claim. Attach itemized statement of all additional charges. 7. Credits: The amount of all payments on this claim has been credited and deducted for the purpose of making this proof of claim. 8. Supporting Documents: Attach copies of supporting documents, such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, court judgments, mortgages, security agreements, and evidence of perfection of lien. DO NOT SEND ORIGINAL DOCUMENTS. If the documents are not available, please explain. If the documents are voluminous, attach a summary. 9. Date Stamped Copy: To receive an acknowledgment of the filing of your claim, enclose a stamped, self-addressed envelope and copy of this proof of claim.

Penalty for presenting fraudulent claim: Fine up to \$500,000 or imprisonment for up to 5 year, or both. 18 U.S.C.§152 and §3571

Sign and print the name and title, if any of the creditor or other person authorized to file this claim (attach copy of power of attorney, if any)

Retucca Shacker, RN / Rebecca Thacker, RN